STATE OF CONNECTICUT
OFFICE OF THE CHILD ADVOCATE
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TESTIMONY OF THE OFFICE OF THE CHILD ADVOCATE
COMMITTEE ON CHILDREN, TUESDAY, FEBRUARY 21, 2023

Senator Maher, Representative Linehan, Senator Seminara, Representative Dauphinais, and all distinguished members of the Committee on Children, this testimony is being submitted on behalf of the Office of the Child Advocate ("OCA") in support of the following bills. The obligations of the OCA are to review, investigate, and make recommendations regarding how our publicly funded state and local systems meet the needs of vulnerable children.

SB 2 AN ACT CONCERNING THE MENTAL, PHYSICAL AND EMOTIONAL WELLNESS OF CHILDREN.

OCA supports Senate Bill 2 which includes several provisions essential for the promotion of children's mental health and wellbeing. Multiple sections address mental health workforce concerns, including Section 1 which would add staff to the Department of Public Health's licensing unit; Section 13 which reduces the license application fees for social work licenses, and Section 14, which makes licensure renewal biennial instead of annual. As the NASW testifies, "CT has, by far, the highest social work license fees on an annualized basis of any jurisdiction in the nation."

OCA supports changes to state law in Sections 5 through 7 which would require the early intervention (IDEA Part C) documents, including the "individualized family service plan" be translated into Spanish for any family whose primary language is Spanish.

OCA supports Section 8 which permits many workers to access "mental health wellness days" as part of their paid sick leave.

Section 9 requires DSS to provide Medicaid reimbursement for suicide risk assessments and other mental health evaluations and services provided at a school-based health center or public school. Just one week ago, the U.S. Centers for Disease Control released a new report analyzing the most recent data and trends from its biannual Youth Risk Behavior Survey.[1] The YRBS surveys almost twenty thousand students across the country to generate the data regarding adolescent wellbeing.[2] The CDC

[1] https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf
[2] According to the CDC: "In each survey cycle, the national YRBS uses a three-stage cluster sample design to produce a nationally representative sample of students in grades 9–12 attending public (including charter schools), Catholic, and other non-public schools in the 50 states and the District of Columbia… Survey procedures are designed to protect students' privacy by allowing for anonymous and voluntary participation. Before survey administration, local parental permission procedures are followed… For the 2021 national YRBS,

conducts the national Youth Risk Behavior Survey (YRBS) every two years, most recently in 2021, among a nationally representative sample of U.S. public and private high school students. The survey asks youth questions regarding a range of behaviors including substance use, suicidal thoughts and behaviors, experiences with violence and poor mental health, social determinants of health such as unstable housing, and protective factors such as school connectedness and parental monitoring. The CDC's most recent report found that over the last 10 years, and evidenced in the recent data, most youth risk indicators have worsened. Excerpts from the CDC report issued this week include these alarming statistics:[3]

> **As we saw in the 10 years prior to the COVID-19 pandemic, mental health among students overall continues to worsen, with more than 40% of high school students feeling so sad or hopeless that they could not engage in their regular activities for at least two weeks during the previous year—a possible indication of the experience of depressive symptoms. We also saw significant increases in the percentage of youth who seriously considered suicide, made a suicide plan, and attempted suicide.**
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> **Across almost all measures of substance use, experiences of violence, mental health, and suicidal thoughts and behaviors, female students are faring more poorly than male students. These differences, and the rates at which female students are reporting such negative experiences, are stark.**
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> **In 2021, almost 60% of female students experienced persistent feelings of sadness or hopelessness during the past year and nearly 25% made a suicide plan.**
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> **Close to 70% of LGBQ+ students experienced persistent feelings of sadness or hopelessness during the past year and more than 50% had poor mental health during the past 30 days. Almost 25% attempted suicide during the past year…**

The CDC recommends a system wide commitment to strengthening protective factors for children and increasing children's access to critical mental health assessments and care.

Connecticut Suicide Data 2021 To Present

OCA is a permanent member and co-chair of the state's Child Fatality Review Panel (CFRP). We continue to see children as young as 11- and 12-years old die by suicide in our state, consistent with national trends showing the age of children dying by suicide is decreasing. Suicide is now one of the leading causes of death for children starting at age 10. Below is recent Connecticut data on youth suicide.

17,508 questionnaires were completed in 152 schools. The data set was cleaned and edited for inconsistencies. Missing data were not statistically imputed. After editing, 17,232 questionnaires were usable. The school response rate was 73%, the student response rate was 79%, and the overall response rate, which is the product of the school and student response rates, was 58%." YRBS Report at 77-79.

[3] https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf

Row Labels	Count of Race
Black	3
Hispanic/White	4
Other	1
White	18
Total	**26**

Row Labels	Count of G
F	10
M	16
Total	**26**

Row Labels	Count of Age at time of Death
11.0001-12.0001	3
12.0001-13.0001	3
13.0001-14.0001	3
14.0001-15.0001	2
15.0001-16.0001	2
16.0001-17.0001	5
17.0001-18.0001	8
Grand Total	**26**

CT: MEANS OF SUICIDE

4- involved a gun

17- asphyxiation

It is imperative that we address the public health crisis of children's mental health from all fronts: strengthening services and basic needs assistance for children and families, increasing funds for our

schools to provide multi-tiered systems of support, adequately funding our children's behavioral health system, and prioritizing the needs of our children. As the U.S. Surgeon General heralded in its 2022 Report, "Our obligation to act is not just medical—it's moral. I believe that, coming out of the COVID-19 pandemic, we have an unprecedented opportunity as a country to rebuild in a way that refocuses our identity and common values, puts people first, and strengthens our connections to each other."

S.B. No. 1051 (RAISED) AN ACT CONCERNING CHILDREN'S SERVICES./S.B. No. 1056 (RAISED) AN ACT CONCERNING CHILDREN'S SAFETY.

As these are general language bills regarding DCF, OCA offers a few specific comments:

OCA supports the state's child protection goals of maintaining children with their families whenever safely possible. OCA's work in recent months has helped us to identify a number of system priorities: the need to support and monitor DCF's safety practice with higher risk/higher need families; a need to improve timely access to effective in-home substance use treatment and basic need supports for families struggling with fentanyl use and other substance use disorders; and the need to assess whether DCF has necessary resources or has allocated adequate resources to conduct sustained quality assurance activities in a transparent manner.

It is important to acknowledge the systemic gains demonstrated by DCF in recent years, including the state's exit from the *Juan F.* consent decree and a separately required federal Performance Improvement Plan. Yet, the exit from involuntary federal court supervision should not mean the end of structured monitoring and public review of performance and agency needs. DCF remains in a first-responder role with highly vulnerable children and families, and there will always be a need for structured, routinized, and public progress monitoring of the state's child welfare system. In this way, system needs, including service gaps for children and families, can be timely reviewed and addressed with stakeholders, and system improvements sustained and supported with adequate resources over time.

OCA Recommendations to Legislators

1. Require DCF to implement ongoing quality assurance regarding safety planning practice for children under DCF supervision. Quality assurance should include information regarding the timely availability and utilization of services necessary to mitigate child safety concerns in the home.
2. OCA recommends revival of the Children's Report Card codified in Connecticut General Statutes §2-53m to regularly review information from DCF regarding children's safety, permanency, and wellbeing, and injury prevention. We appreciate the Committee's receptiveness to this concept.
3. That the legislature hold an informational public hearing to review available services and supports for families when a caregiver has an opioid use disorder. The hearing should include feedback from the OCA, DCF, Department of Mental Health and Addiction Services, CT Judicial Branch Court Support Services Division, community providers, and family

advocates/individuals with lived experience. The hearing can then inform needed investments and resource allocations during this important budget session.

H.B. No. 6718 (RAISED) AN ACT CONCERNING THE SAFE STORAGE AND DISPOSAL OF PRESCRIPTION DRUGS, CANNABIS AND CANNABIS PRODUCTS.

OCA strongly supports the provisions in this bill to require (1) printing of statements directing consumers to information concerning the safe storage and disposal of prescription drugs, cannabis and cannabis products on containers, packaging or receipts for such items, and (2) Department of Consumer Protection to develop and administer a public awareness campaign concerning the safe storage and disposal of such items.

As the U.S. Food and Drug Administration warned just last year:[4]

- Edible products containing tetrahydrocannabinol (THC) can be easily mistaken for commonly consumed foods such as breakfast cereal, candy, and cookies, and accidentally ingested.
- Accidental ingestion of these products can lead to serious adverse events, especially in children.
- Some edible products are designed to mimic the appearance of well-known branded foods by using similar brand names, logos, or pictures on their packaging. These copycats are easily mistaken for popular, well-recognized foods that appeal to children.

In addition, national poison control centers received 10,448 single substance exposure cases involving only edible products containing THC between January 1, 2021, and May 31, 2022. Of these cases, 77% involved patients 19 years of age or younger. Of the total cases, 65% involved unintentional exposure to edible products containing THC and 91% of these unintentional exposures affected pediatric patients. Furthermore, 79% of the total cases required health care facility evaluation, of which 7% resulted in admission to a critical care unit; 83% of patients requiring health care facility evaluation were pediatric patients.

It is essential that "consumer health materials" and warnings referenced in the proposed bill are explicit regarding the dangers of accidental ingestion or overdose of cannabis and other substances by children. The warnings may also be amended to include the FDA's "Recommendations for Consumers:"

- Call 9-1-1 or get emergency medical help right away if you or someone in your care has serious side effects from these products. Always keep these products in a safe place out of reach of children.
- Call the local poison control center (1-800-222-1222) if a child has consumed these products. Do not wait for symptoms to call.

[4] FDA Warns Consumers About the Accidental Ingestion by Children of Food Products Containing THC, June 16, 2022. https://www.fda.gov/food/alerts-advisories-safety-information/fda-warns-consumers-about-accidental-ingestion-children-food-products-containing-thc

- Contact your healthcare provider if you or someone in your care recently ingested these products and you have health concerns.

Cannabis ingestions in children have been increasing over the past several years in Connecticut, since Massachusetts made the sale of cannabis legal in 2019. Between 2019 and early 2022, cannabis ingestions/exposures by children and adolescents reported to the Connecticut Poison Control Center increased by 350%. Most of these exposures were accidental, meaning that the children inadvertently consumed these products, usually in the form of edibles (e.g., gummies, chocolate).

Children younger than 5 years old who consume cannabis are most likely to be symptomatic and require hospital care. Even a small exposure of a cannabis-containing product can lead to significant symptoms in children, due to their lower body weight. As many edible products are packed as candies and chocolates, children may consume multiple pieces - leading to very serious symptoms. Ingestion of THC in children can lead to a wide range of serious medical consequences, including coma and seizure.

Connecticut's cannabis laws include many important safeguards. However, if products are stored in ways that are still accessible to children, these safeguards may be moot. Thus, a public health campaign focused on caregiver education about safe storage of cannabis products is essential.

We look forward to working with you to prevent further cannabis ingestions by children in Connecticut.

H.B. No. 6719 (RAISED) AN ACT CONCERNING EMERGENCY SERVICES AND INDIVIDUALS WITH AUTISM SPECTRUM DISORDER, COGNITIVE IMPAIRMENTS AND NONVERBAL LEARNING DISORDERS.

OCA supports this bill which would require the development of municipal guidelines and best practices for emergency services awareness of, response to, and engagement with children with various developmental disabilities, including cognitive impairments and autism. It is imperative that first responders have tools and training to interact in a developmentally appropriate and non-harmful way with individuals who have developmental disabilities.

For several years OCA has monitored school-based arrests of children age 12 and under. In November 2020 the OCA published an investigation into Waterbury Public Schools' reliance on police to respond to the behavioral crises of students in PreK through Grade 8 schools.[5] OCA found that during a six-month period of the academic year, the PreK through Grade 8 schools called police just under 200 times to respond to the behavior of children as young as 5 years old. These calls led to 36 arrests, all misdemeanors, of students, including nine children age 11 and younger. Approximately 90 children were taken to local emergency departments. The majority of police reports described children as having disabilities or "special needs." A few children were the subject of several reports, and these

[5] https://portal.ct.gov/-/media/OCA/OCA-Recent-Publications/OCA-Report--Final-Waterbury-Report-September-1-2020.pdf.

children were all described in police records as students with disabilities. The children with the most reports were identified in police records as children with Autism.

> Officer dispatched to SCHOOL on a mentally ill person complaint. Upon arrival to the school, this Officer was able to hear a student screaming all the way outside. … As I entered the classroom, I saw a female student, 8 years old CHILD, being restrained by school staff because they were stopping her from hurting herself and others. As soon as they let CHILD loose, she began to scratch her wrist with a [sic] nails. When her teacher attempted to stop CHILD from scratching herself, CHILD attempted to scratch TEACHER with her nails. Due to CHILD'S assaulting and self-injury behavior, I immediately placed her in handcuffs, in an attempt to stop her from injuring herself or others. As soon as I placed CHILD in cuffs, she immediately calmed herself down. As soon as Ambulance arrived, CHILD sat on the stretcher and I removed the cuffs. I spoke to teacher, who stated that during class, CHILD was misbehaving, so she decided to take away the recess time. When CHILD found out that she had lost recess, she became very agitated and combative. She then began to slam her head on a table and then grabbed a pencil to stab herself. When CHILD heard TEACHER telling me about the pencil incident, CHILD stated "because I lose my recess, so I don't want to live anymore." Based on the statements and from what I observed, I believe CHILD to be a danger to herself and others and in immediate need of medical evaluation. … at HOSPITAL I met with CHILD's MOTHER. … MOTHER stated that CHILD is Autistic.

> OFFICER was dispatched to SCHOOL regarding a complaint of a 9 year old student who was acting out and hitting teachers. Upon my arrival, I spoke with the complainant who is a special education teacher employed here. TEACHER said that one of her students suffers from autism. She said that CHILD was not listening to directions and she was in a crisis. That CHILD was throwing things around the classroom and said that she can be violent. She said that this was the third time that CHILD has become irate in school and that on two previous occasions she has threatened suicide so she removed the shoelaces from CHILD'S shoes. She said that CHILD had banged her head on the wall, causing a bruise on her forehead and that she had also bit herself on the arms. TEACHER said that she had called CHILD'S mother numerous times, but she did not answer and did not call back as of yet. She said that she feels that the mother is not answering because she is tired of coming here to the school to pick up her daughter. This Officer observed a small bruise in the center of CHILD'S forehead and numerous old bruises all over both of her arms. CHILD was yelling and screaming at times while I was here and she refused to speak to this Officer. CHILD finally calmed down and AMR ambulance placed her on a stretcher without violence, and CHILD was later transported to HOSPITAL for evaluation. The Vice Principal also rode in the ambulance to the hospital with CHILD, and she would stay at the hospital until the mother could notified and also respond there.

As OCA wrote in its 2020 report:

> Concerned, overwhelmed, and under-resourced school administrators may rely on police to respond to children's crises, seeing police intervention as a rapid way to address a child's behaviors, ensure a safe school environment, or as an effective strategy to access hospitalization and crisis support….Unfortunately, use of law enforcement as a behavioral health first response system is problematic and does not increase the likelihood of a child and their caregiver becoming well connected to community supports…. As the Waterbury Police Department acknowledged, law enforcement officers generally are not trained in children's behavioral health or how to work with children who have disabilities, and they are not responding to schools with support from or as part of a coordinated community mental health response.[6]

According to the U.S Substance Abuse and Mental Health Services Division (SAMHSA), a Division of the U.S. Department of Health and Human Services, *National Guidelines for Behavioral Health Crises*:

> In many communities across the United States, the absence of sufficient and well-integrated mental health crisis care has made local law enforcement the de facto mental health mobile crisis system. This is unacceptable and unsafe… [While] the role of local law enforcement in addressing emergent public safety risk is essential and important. … unfortunately, well-intentioned law enforcement responders to a crisis call often escalate the situation solely based on the presence of police vehicles and armed officers that generate anxiety for far too many individuals in a crisis.[7]

As OCA wrote only two years ago, "A national conversation is taking place regarding the role of police in schools and how reliance on law enforcement in our schools to provide security and behavior management has overtaken investment in children's mental health, mentorship, support for teachers and other educators, and investment in human services, a lack of investment that most harshly impacts children and communities of color, often children with disabilities. It will be essential to reverse this trend to further the public health goals of supporting children's wellbeing and combatting the impact of systemic racism on vulnerable children."[8]

Respectfully submitted,

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[6] OCA Report at 4.

[7] United States Substance Abuse and Mental Health Services Administration, National guidelines for Behavioral Health Crisis Care: Best Practice Toolkit, pg. 33 (emphasis added).

[8] OCA Report at 6.